I remember one child who was particularly hard to manage and would not allow me to give treatment or medicine without a struggle, which so taxed his strength that I thought it would overbalance all the good that could ensue, and wondered if it had not better have been left undone. Then I stumbled onto an idea, that perhaps he would enjoy being some one else (he was only two), so I called him Susie, saying, "Open your mouth, Susie, and take your medicine." He responded immediately, glad to have Susie get the bitter dose. I had no more trouble through his entire illness, always giving the disagreeable things to Susie.

So the day passes, and when night comes on we start with the dollies and the doggies, and the little moo-cow, putting them all to bed first, and baby is almost always willing to join his pets when his turn comes.

The child a little older will enjoy kindergarten amusements, colored beads and crayons, paper dolls, or a race of marbles across the cutting board, paste-board houses and furniture, both of which are easily made. There are so many, many ways to amuse and entertain a child, even though they have few toys. Many a gorgeous necklace have I made for the small girl out of the diamonds from an old pack of playing cards, and many a garage, for the small boy, has been filled with advertisements from an old magazine. Hours have passed pleasantly for the girl of eight, while she watched me fit a petticoat or dress to her dolly; while the boy, that age, will have great fun sticking old stamps into a scrap-book, and thus the days go by rapidly, both for patient and for nurse, if she does not dislike the work.

Many a nurse is excellent with adults, but does not possess the peculiar knack of caring for a child, but fortunately more nurses are seeking experience in this line.

A good nurse is as necessary to a sick child as a good doctor, for the skill of the doctor cannot avail unless his directions are carried out to the letter.

EMERGENCY CARE OF THE MENTALLY DISORDERED

By SMITH ELY JELLIFFE, M.D.

Part II

(*Continued from page* 401)

The delirium found in the patient who is suffering from a mental disease which we term general paresis, or softening of the brain, is usually quite different. It may be characterized by a loss of orientation and of violence; there may be hallucinations of sight and of hearing,

but its constantly-shifting nature, the mixture of extremely bizarre, incoherent, and uncoördinated actions, with marked changes in the distinctness of speech, with tremors, is classical. The patient usually shows a markedly happy, self-satisfied and self-laudatory mood which is in contrast to the more or less anxious mood of the toxic delirium patient.

The excitement of a patient suffering from the manic phase of a manic depressive psychosis is also marked by a happy exuberant mood, but the patient is usually remarkably clear. He has loss of orientation only in the severest grades of maniacal stupor. The manic excitement is further characterized by a lively interest in the things about him—by marked irritability and contentiousness, aggravating mischievousness or malicious destructiveness. Plain deviltry may be the general attitude of the manic. He is excessively divertable not only in his speech, which is usually clear and distinct, hopping from one subject to another, usually with considerable logic and force, but also in his movements. The slightest movement or sound causes him to take up a new line of action or of speech and he snaps out his answers or phrases, and then laughs or sighs or rolls up in the bed clothes, all as though it were great sport. Hallucinations and delusions are not characteristically in the foreground.

It is extremely difficult for the untrained eye to distinguish the delirium of a manic patient from that of a paretic, and many trained eyes cannot do it, but in the average run of cases, it will be seen that the mental deterioration of the paretic is in evidence, while the excited manic shows little or no evidence of intellectual impairment.

One other feature of the mild manic case which it is important for the nurse to observe and record, is the tendency to the expression of delusional ideas of persecution. The French gave the very excellent name "reasoning folly" to these patients because of their continued contentiousness, and argumentativeness, combined with suspiciousness, and sometimes with long, complicated, and elaborate plots about poisoning, or efforts to do away with property, or suggestions regarding cliques, and crowds, and gangs, who get together for the patient's undoing in various ways. Whereas though one may find similar delusional developments in the paretic, as a rule the apparent logicalness of the whole scheme will be marred by grossly incongruous, and even foolish elements. The paretic, in unfolding a long story about persecution, is more likely to introduce some fantastic, bizarre, absurd, or plainly demented element in the plot, thus spoiling its congruity. Such little factors should be carefully noted for the physician's guidance, and are also useful in affording insight into the patient's own mind and its disorder, and thus offer clues as to modes of handling these ideas. Both types of patients can be, at times, diverted

from the thread of their thoughts, and a little practice, with definite ideas behind them, makes one skilful in handling these cases.

Another real difficulty in handling manic cases arises in those mild cases, particularly, in whom there is a tendency toward scornful irritability. These patients are apparently not suffering from any mental disturbance, but are so intensely disagreeable that it is with the greatest difficulty that one can keep one's temper. They are often unusually bright and witty, but their wit is biting, sarcastic and extremely annoying, they seem to take a malicious pleasure in hurting one's feelings or in sharp answers and keen thrusts and complaints that the nurse is tempted to retort and for the moment forget that she is dealing with a diseased mind, and not a disagreeable person. Natural capacity to turn these thrusts is invaluable, but much can be done with practice in acquiring a method of leaving these patients much alone without seeming to neglect them. In this same category one can place the irritable alcoholic and drug case.

Another type of excitement is met with in the senile case. These can often be managed just as the paretic. Falling in with their whims will avoid a difficulty, as in the case mentioned by Dr. Barrus, of the senile dement who always wanted to go home, who would get out of bed, dress, and nothing could prevent his going out. Here the patient was permitted to go out, was walked around the block, and then arrived home and put to bed again, perfectly contented. I can quote you the familiar story of Dr. Clouston, the well-known Scotch alienist, who encountered one of his delusional patients at the top of a high cliff on one occasion. The patient grasped the doctor and told him he was going to throw him down to the bottom of the cliff. Instead of resisting, Dr. Clouston said, yes, that would be a good thing, and would show how strong a man he was, but he gravely remarked, "You see, such a strong man as you could throw me from the bottom to the top; suppose we go down and try it?"—to which the patient is said to have acquiesced, and on reaching the bottom other methods of extricating himself from his difficulty suggested themselves. This is only a small indication of the kind of tact that often has to be used in handling excited delusional patients.

Now let me turn to another aspect of our subject entirely. I refer to the various methods of restraint that may have to be utilized with patients who are too violent to be handled by the methods of which I have spoken. First: How should an excited individual be approached? Never try to handle a violent person alone,—two, or even three, are required. In taking hold of the patient the best method is for one nurse to grasp the

left wrist with her left hand, and the elbow with the right, another nurse grasping the right wrist with her right hand, and the elbow with the left, and then, both standing by the side of the patient, slowly push him backwards into a chair already provided, and brought up close to him. Never try to drag a patient along,—back him, and as you push him slightly backwards, the involuntary attempt to keep his balance will enable you to walk him directly into a chair, where he can be held until further assistance can be obtained. Avoid roughness as much as possible.

As to means of restraint for excitement, three general kinds may be mentioned; these are chemical, mechanical and hydrotherapy. Chemical restraint, by means of drugs, comes within the province of the physician, and no nurse would give a narcotic of her own initiative. Chemical restraint is frequently necessary, and clearly indicated from all points of view, but the drugs used are often extremely dangerous, and the responsibility involved should not be thought of lightly. If, in filling a physician's orders, you are called upon to administer such narcotics as chloral, paraldehyde, veronal, trional, morphine, hyoscine, or the like, you should never forget their poisonous properties. Great care must be taken in following exactly the directions as to dosage, and the drug should not be left in places accessible to the patient. The patient's own peculiarities should guide you as to the means of administration, but in general it is wisest to so give them as to attract the least amount of attention possible to the process. For this reason, the food is often one of the best vehicles to utilize. In delirium many patients will refuse to drink out of a spoon, but will take water or milk or other substances from a cup. A suspicion of an alcoholic drink, a drop of whiskey perhaps in the cup, will cause a delirium tremens patient to swallow a disagreeable dose without a word. Glass tubes and breakable articles should be avoided with the delirious, the confused and excited. For certain very resistant or suspicious patients rectal administration is alone practical. For others hypodermic methods are more advantageous.

Chemical restraint is very old. The ancients employed hyoscyamus (from which our modern hyoscine is obtained) very widely. It was held to be the sovereign remedy in all the psychoses, and at one time an island, Anticyra, upon which hellebore grew in large quantities, enjoyed a great reputation as a place to which the mentally diseased were sent for treatment. At the present time, however, it has come to be recognized that, after all, chemical restraint is far from ideal, and often works great detriment to the mind, chiefly because the remedies employed either so diminish bodily metabolism as to constitute a danger from this cause, or they so depress the nervous tissue as to do more harm than they do

good. It is for these reasons chiefly that chemical restraint has given way to hydrotherapy.

Mechanical restraint, speaking generally, is the worst form of restraint. It excites the patient, and from continual irritation keeps up a motor excitement that works to great disadvantage. Last year, while in Berlin, working in the Charité Hospital I could see in the court of the psychiatric clinic several dogs, portions of the brains of which had been removed. In one, the entire cortex had been taken away, leaving only the basal ganglia. All the thinking apparatus was gone, all that was left was the centres for reflex activity. If left alone and undisturbed this dog would lie or sit perfectly quiet, but when the operator placed a tin pincher on his tail he immediately got up and ran about the yard in a stumbling fashion. The irritation being constant, the dog continued to run about, and only lay down when the pincher was removed. The delirious patient is in a somewhat similar condition. His thinking cortex is partly removed by the influence of his disease, and any irritating bands or straps, acting like reflex centres, make him furious. He beats and threshes to have them removed, and often the pressure of clothing, or the bed clothes alone, is enough to start the motor excitement. It is therefore imperative to use as little mechanical restraint as possible in handling violent patients. Occasionally, however, it is imperative that some sort of restraint be used. Straight jackets are out of fashion. Short muslin or canvas shirts, with sewed sleeves, are better and more serviceable. The control sheet which spreads over the patient, giving him freedom to move around within it, is also desirable at times. Occasionally a patient must be tied in bed. Here the ordinary bed sheets are the best to use. The feet can be securely fastened by broad bands, and then the ends fastened to the foot of the bed; but free play of at least a foot should be allowed each leg. A sheet can then be tied across the chest, with say 4 to 6 inches free play, and the hands fastened by sheets right and left, with play enough to permit brushing flies off the face, blowing the nose or other simple acts. To tie hand and foot hard down to the side and foot of bed is unnecessary and inhumane. Even when tying is necessary do not forget these excited periods are usually transitory only, after which the patient should be immediately released, having been tied up only 10 to 15 minutes. One is as much justified in keeping such patients tied up as one would be in locking up a drunk man for his life for fear when he drank again he would do some damage. Special forms of mechanical contrivances may have to be thought out for patients who show stereotyped movements, such as pounding the elbows or fists upon hard objects, or other movements which would result in localized injuries.

Hydrotherapy, however, is the best form of quieting excited and destructive patients. This can be given either by means of the hot pack, the wet sheet, the hot bath, or the continuous bath. The wet sheet and the hot pack provide hydrotherapy and mechanical restraint at the same time, but are rarely as useful as the continuous bath for the very excited patients. They are of great service for periodic restlessness and excitement. The hot pack is usually preferable. They resist as a rule in the beginning of the treatment, but usually get to enjoy it, and sometimes will go to sleep and remain in the pack an hour or so, and awake quiet and refreshed. The hot bath is particularly valuable for children who are excited and nervous. The temperature should average about 102°–104° F. They may stay in for an indefinite period.

The best mode of combating mental excitements, especially of the most severe grades, is by means of the continuous bath. As a rule such baths require special construction, and are obtainable only in special institutions,—yet many modern bathrooms are ideal for carrying out the treatment of the continuous bath. Even the most excited patients soon acquire a great liking for it, and do not leave it, or only temporarily will they climb in and out. The most violent maniacal excitements of paretics, dementia præcox cases with excitement, and manics are benefited for the most part by the continuous bath. The bath is so arranged that the flow of water is almost constant, and a proper mixer keeps the temperature at a proper heat—93°–98°. Some baths have electrical appliances to keep a check on the temperature, for in some stuporous excitements the patients are unable to protect themselves from being scalded. The patient lies or sits in the bath for hours, or days, or even weeks at a time. Special care must be devoted to the skin which is liable to acneiform eruptions which become easily infected. Special baths are constructed arranging for the passing of the feces and urine in the bath. Under ordinary circumstances the toilet can be utilized. The continuous bath is undoubtedly one of the most valuable aids in the treatment of acute and chronic maniacal excitements.